MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Inpatient Services

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Contents

Simultaneous Kidney-Pancreas Transplant Benefit

Effective retroactively to dates of service on or after July 1, 2005, inpatient providers may be reimbursed for simultaneous kidney-pancreas transplant services. To be eligible for reimbursement, providers must be authorized by the California Medical Assistance Commission (CMAC) to provide kidney-pancreas transplant services.

Providers must bill using the following national revenue and ICD-9 procedure codes:

- National revenue code 201 (intensive care, surgical) or 203 (intensive care, pediatric); and
- The primary ICD-9 procedure codes must be 52.80 (pancreatic transplant, not otherwise specified); and
- The secondary ICD-9 procedure code must be either 55.61 (renal auto-transplantation) or 55.69 (other kidney transplantation).

A *Treatment Authorization Request* (TAR) is required for reimbursement.

Physician Services
Physician services for the kidney-pancreas transplant must be billed "By Report" with HCPCS procedure code S2065 (simultaneous pancreas kidney transplantation). A TAR is required, and the operative report must accompany the claim.

Organ Procurement
Inpatient providers whose contract excludes organ procurement may bill using their outpatient number and HCPCS procedure code S2055 (harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor) for kidney-pancreas procurement. A TAR is required, and an invoice from the relevant organ procurement organization must accompany the claim.

Exception to Claims Timeliness Requirement
As an exception to the standard six-month billing timeliness requirement, a three-month grace period from January 1, 2006 through March 30, 2006 is established to allow providers to submit claims for kidney-pancreas transplant procedures with dates of service on or after July 1, 2005. Claims submitted after this three-month grace period will be subject to the standard six-month timeliness requirement. See the *Claim Submission and Timeliness Overview* section of the Part 1 manual for more information about the six-month timeliness requirement.

Providers who billed and received payment for kidney-pancreas transplants but wish to request an adjustment based on the original claim must submit a *Claims Inquiry Form* (CIF). Refer to the *CIF Overview* section of the Part 1 manual for more information.

This information is reflected on manual replacement pages rev cd ip hipaa cod 2 (Part 2) and transplant 5, 7 and 12 (Part 2).

Patient Status Codes Update

Effective retroactively for dates of service on or after September 22, 2003, inpatient billing codes are expanded to include all national patient status codes.

New Patient Status Code 66
Effective for dates of service on or after January 1, 2006, inpatient providers may bill using patient status code 66 (discharged/transferred to a Critical Access Hospital [CAH]) when appropriate.

The following is the complete list of valid national patient status codes.

Code	Description
01	Discharge to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility with Medicare certification
04	Discharged/transferred to an intermediate care facility
05	Discharged/transferred to a non-Medicare Prospective Payment System (PPS) children's hospital or non-Medicare PPS cancer hospital for inpatient care
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
09	Admitted as inpatient to this hospital
20	Expired
30	Still a patient
40	Expired at home
41	Expired in a medical facility
42	Expired – place unknown
43	Discharged/transferred to a federal health care facility
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to hospital-based Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare certified Long Term Care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)

Note: Providers are reminded that the day of discharge/death is not reimbursable unless it is the day of admission.

This updated information is reflected on manual replacement pages cont ip 7 (Part 2), ub comp ip 8 and 9 (Part 2) and the Code Correlation Guide, pages 2 and 3, at the end of the UB-92 Completion: Inpatient Services section.

Contracted Inpatient Hospital Address Update

The California Department of Health Services (CDHS) selective hospital contracting list has been completely updated. Hospital contracts are continually changing so providers should review the information carefully.

This information is reflected on manual replacement pages contra 1 thru 15 (Part 2).

Procedure Code and Modifier(s) Combination on Claim and TAR Must Match

Effective for dates of service on or after March 1, 2006, the procedure code and modifier(s) combination on the claim submitted must match the procedure code and modifier(s) combination authorized on the *Treatment Authorization Request* (TAR). Failure to do so may result in denial of the claim.

Note: All current policies regarding the placement or order of modifiers on the claim and/or TAR remain the same.

837 v.4010A1 Electronic Claims with Attachments Now Available

Providers now have the ability to submit 837 v.4010A1 electronic claim submissions with attachments by either faxing the attachments or sending them electronically through an approved third-party vendor.

To utilize this new process, providers must be authorized to bill 837 v.4010A1 electronic claims. The fax process includes an *Attachment Control Form* (ACF), which is used as a coversheet for the supporting fax attachments. The ACF has a pre-printed Attachment Control Number (ACN) that submitters input on their electronic claim submission in the PWK segment. Providers submit the electronic claim, then fax the ACF and the attachments to Medi-Cal. Each ACF and corresponding attachments require a separate fax call. Each call to the fax server must include only one ACF as the first page followed by the attachment pages that correspond to that ACF. The phone number to fax attachments is 1-866-438-9377.

The electronic process involves approved third-party vendors that preprocess the attachments and send the images electronically on the provider's behalf. Medi-Cal links the faxed or electronic attachments to the appropriate electronic claim.

Providers have a maximum of 30 calendar days from the date of claim submission to submit the supporting faxed or electronic attachments. For further information regarding attachment submissions, please refer to the *Billing Instructions* section of the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "HIPAA" link on the home page, then the "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link and then the "Billing Instructions" link.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	cont ip 7/8
Remove:	contra 1 thru 19
Insert:	contra 1 thru 15
Remove and replace after the *Revenue Codes for Inpatient Services* section:	*Revenue Code/Accommodation Code Correlation Guide* 1/2
Remove and replace:	transplant 5 thru 8 and 11/12 ub comp ip 7 thru 10
Remove after the *UB-92 Completion: Inpatient Services* section:	*Code Correlation Guide* 1/2
Insert:	*Code Correlation Guide* 1 thru 3
Remove and replace:	ub sub 1/2 *

*Pages updated due to ongoing provider manual revisions.